Community Health Workers (CHWs) in Clinical Setting

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Objectives

Explore Roles and Responsibilities of CHW

Describe integration process of navigation program

Identify project metrics and outcomes

Discuss challenges, barriers, and lessons learned

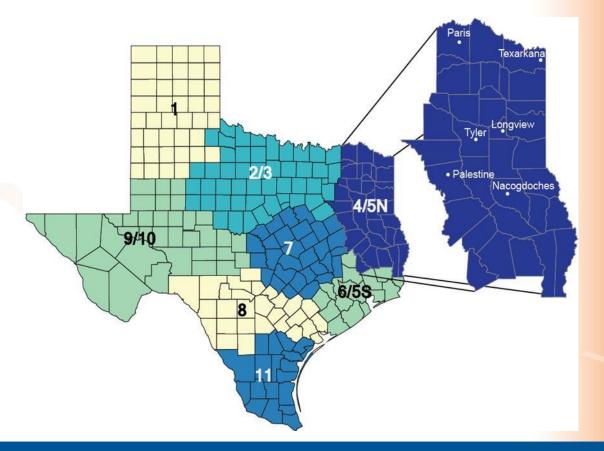


Background

- Higher than average prevalence
 - Chronic Diseases
 - Chronic Obstructive Pulmonary Disease (COPD)
 - Congestive Heart Failure (CHF)
 - Admission Rates
 - Mortality Rates



- 25,000 SQ MI
- 1.5 MILLION
 POPULATION
- 55% LIVE IN RURAL AREA





Northeast Texas as "the 51st state"

Top 5 Causes of Death	TX State Rank*	Northeast TX "State" Rank*
Heart disease	33 rd	49 th
Cancer	13 th	25 th
Chronic lower respiratory diseases	21 st	47 th
Stroke	38 th	51 st
Unintentional injuries	9th	34 th
All causes	31 st	45 th

^{*}A rank of 1=best (lowest) rate, 51=worst (highest) rate, based on age-adjusted mortality rates for top 5 causes of death. *Adapted from*: Nehme E, et al. The health status of Northeast Texas 2016, a report from Dr. David L. Lakey, UT System CMO and Assoc. Vice Chancellor of Population Health, Table 3, p. 11. DSHS HSR Region 4/5N, 35 counties, 1.5 million inhabitants.



Methods

- Patient Care Navigation Project
 - Primary Care
 - Specialty Care (Cardiology, Pulmonary, Oncology, Surgical, and Women's Wellness)
 - Inpatient/ICU
 - ED
- Behavioral Health Integration Project (Primary Care)
- Patient Centered Medical Home



Community Health Workers

- Job Description
- Pay Scale
 - Certified through Department State Health Services
- Department of Labor CHW Apprenticeship Site
- Skills Assessment
 - Comprehension
 - Math
- Supervisor Nurse Manager
- Training Checklist
- Performance Initial/Annual Review
 - Competencies



Community Health Worker Training Checklist

Instructions: To be completed by the CHW Instructor or an assigned designee. Once all training is complete signatures of CHW, CHW Instructor, and Nurse Manager are required. A copy will be kept on file by the CHW Training Program, Human Resources, and Nurse Manager. You may also retain a copy for our records.

Community Health Worker Training - Date Comp <mark>let</mark> ed:
Community Health Worker Application - Date Completed:
DSHS CHW Certification Received - Date Completed:
 Renewal – 2 years (20 CEUs required [10 DSHS and 10 Non-DSHS])
YourTexasBenefits.com Navigator Training - Date Completed:
 Renewal – 1 year
Disability, SSI/Medicaid and Medicare Training – Date Completed:
 Yearly updates
WE Care Charity Program Training – Date Completed:
Department of Family and Protective Services Mandatory Reporter Training - Date Completed:
Affordable Care Act Marketplace Certified Application Counselor Training - Date Completed:
 Renewal - 1 year
Electronic Health Record Training with Information Technology - Date Completed:

Includes PSC/CHW Template



	Electronic Health Record Scheduling Trainin	ng with Patient Access - Date Completed:	_								
	American Heart Association Basic Life Supp	Forms Training, Updates, Practice – Yearly Not ALL CHWs will receive this training, only selected clinic positions Ition with Nursing Education - Date Completed: ientation and Training with Nurse Manager or Charge Nurse - Date Completed:									
	 Renewal – 2 years 										
	Mental Health First Aid Training - Date Com	pleted:									
	Renewal – 2 years										
	Home Visit Safety Training - Date Complete	ed:	10								
	Advance Care Planning: Respecting Choices ACP Facilitator – Date Completed:										
	 Not ALL CHWs will receive this training, only selected clinic positions 										
	Nursing Orientation with Nursing Education - Date Completed:										
	Clinical Area Orientation and Training with	Nurse Manager or Charge Nurse - Date Completed:									
			<u> </u>								
Signatu	re of Community Health Worker	Printed Name of Community Health Worker	Dz								
Date Si	gned	-									
Signatu	re of Nurse Manager	Signature of CHW Instructor									



Printed Name of CHW Instructor

CHW Competencies

- 1. Communication: Express ideas effectively. Organizes and delivers information appropriately. Listens actively.
- 2Teamwork: Interacts with team effectively. Able and willing to share and receive information. Cooperates within the group and across groups. Able to effectively deal with diverse individuals.
- 3.Decision Making/Problem Solving: Uses sound judgement to make good decisions based on information gathered. Considers all pertinent facts and alternatives before deciding on the most appropriate action. Contacts designated clinic staff, management, PSC to ask questions and obtain further clarification and understanding.
- 4. Organization: Organizes tasks and work responsibilities to achieve objectives. Sets priorities. Uses resources properly. Pays close attention to detail, accuracy, and completeness. Shows concern for all aspects of job. Follows up on work outputs. Adapts to changing environment, work priorities, and organizational needs.
- 5. Initiative: Takes personal responsibility for job performance.
- 6.Integrity/Stress Tolerance: Shares complete and accurate information. Maintains confidentiality. Deals with difficult situations while maintaining performance. Seeks support from others when necessary. Uses appropriate coping techniques.



Pay Scale Comparison

											1	11		Ţ				RN									
											PSC																
				CASE MANAGER/SOCIAL WORKER																							
			LVN																								
CHW									1																		
\$	16	\$ 17	\$	18	\$	19	\$	20	\$	21	\$	22	\$	23	\$	24	\$ 25	\$	26	\$	27	\$	28	\$	29	\$	30

Dollars/Hour

CHW Roles and Responsibilities

- Medication Assistance (through Needy Meds [PAP] and/or Extra Help for Medicare recipients)
- Insurance Assistance (through ACA Marketplace and/or Your Texas Benefits re: Medicaid/CHIP/ Medicare Savings Program [MSP])
- ☐ Social Security/SSI Disability Assistance
- ☐ TANF/SNAP Assistance
- ☐ DME Assistance
- Assistance finding a medical home/referrals
- ☐ Teaching individual/group classes to include DEEP, Heart Healthy, and Chronic Disease Self-Management



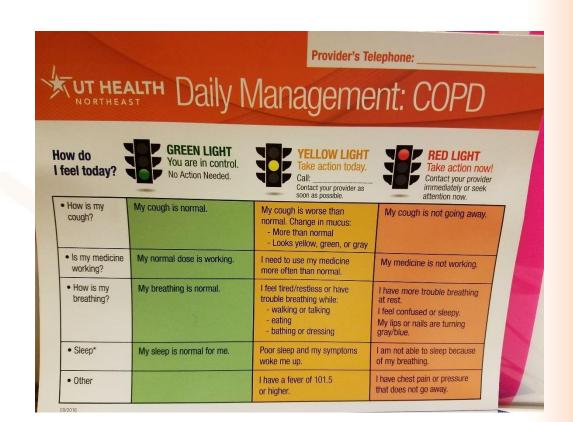
CHW Roles and Responsibilities

- Conduct Home Visits to uncover emotional, social, environmental, or other barriers to care
- Chronic Disease/High Risk patient assessment for health needs and barriers to care (completed using EMR template)
- □ Pre-Visit Planning Calls
 - □ Remind Clients of Health Maintenance Items
 - Assistance with transportation
- Community Outreach



Patient Education

Stopligh t Tool





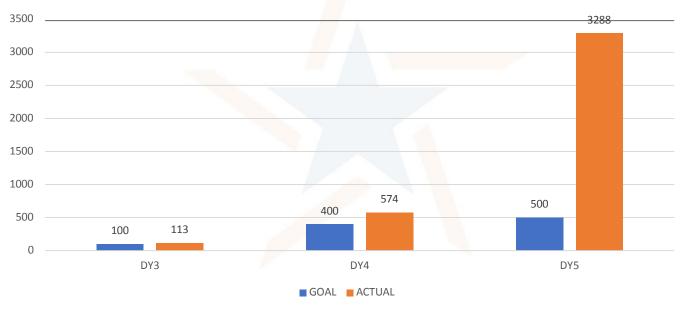
METRICS

- Increase the number of targeted patients enrolled into the Patient Navigation program
- o Increase the number of patients without a Primary Care Provider in obtaining a Primary Care Provider appointment
- o Reduce Emergency Department visits for those with an Ambulatory care Sensitive Condition (Heart Disease, COPD, Asthma, Diabetes, &. Grand Mal Seizures)
- o Increase the number of continuity clinic sessions in the community



Findings & Outcomes

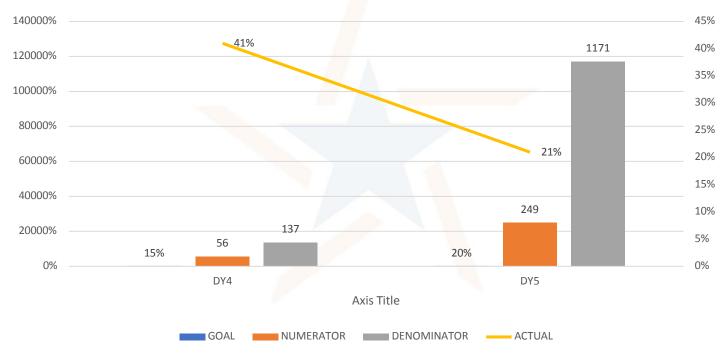






Findings & Outcomes

PCP APPOINTMENTS

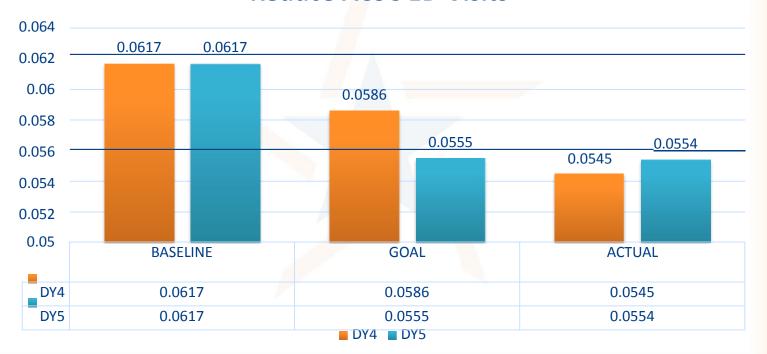




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Findings & Outcomes

Reduce ACSC ED Visits





Findings & Outcomes

UNIQUE PATIENT ENCOUNTERS





Hypertension Project

- March June 2017
 - Developed policy and procedures
 - Blood Pressure Cuff Training
 - Cohort of 40
 - Orientation
 - Bi-Weekly Workshops
 - Incentives
 - 12 Weeks
 - Average Outcomes
 - Reunion Workshops



Hypertension Project

- March June 2017
 - Patient Tracking (150)
 - Lending Library
 - Follow-up
 - Lessons Learned
 - Successes
 - Challenges and Barriers
- Future ~ October June 2018
 - Updated Workshop Protocols
 - New Cohort of 40



Lessons Learned

- Communication is Critical
- ☐ CHW Scope of Practice
- □ Continued Mentoring and Support
- ☐ Selection Process
- □ Cultural Sensitivity
- ☐ Silos vs. Teams
- ☐ Stakeholder Education



THANK YOU!



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References

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